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Motivational Coaching: A Functional Juxtaposition of Three Methods for Health Behaviour Change: Motivational Interviewing, Coaching, and Skilled Helping

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Abstract

The purpose of this paper was to explore the unique qualities/characteristics/components of the Co-Active coaching model compared to Motivational Interviewing and Egan's Skilled Helper Model. Six questions pertaining to the creation, purpose, and process of the therapeutic alliance; and the relationship between practitioner and client were used to guide comparisons. Given the similarities among all three methods, it cannot be said that any of them are necessarily distinctive in their core principles or tenets. Instead, their uniqueness lies in the way that they are packaged and delivered. A model of Motivational Coaching, informed by this study's comparative analysis of the three models/method analyzed in this paper, is presented. Our intent is to distil into one framework the key components of three important and overlapping methods used in working toward behavioural changes.

Keywords: Co-Active life coaching; Motivational Interviewing; Egan's Skilled Helper Model; Behaviour change

Introduction

Life coaching is a relatively new practice that has gained attention, recognition, and criticism from a variety of different professions. Over the last ten years it has been utilised in health field in areas such as diabetes (Joseph, Griffin, Hall, & Sullivan, 2001); fitness (Tidwell, Holland, Greenberg, Malone, Mullan, & Newcomer, 2004); mental health (Grant, 2003); obesity (Newnham-Kanas, Irwin & Morrow, 2008; van Zandvoort, Irwin & Morrow, 2008; 2009); and cancer (Brown, Butow, Boyer, & Tattersall, 1999) to name a few (for a full overview of coaching-related health studies see Newnham-Kanas, Gorczynski, Morrow & Irwin, 2009). Traditionally, the prevailing trend and professional training in health care has relied on providing patients and clients with information about health (together with the assumed client impact-factor of professional status); specifically, health information has been directed toward primary care and the treatment of illness to the detriment of a complementary focus on prevention (see Elder et al., 1999). Thus the use of coaching and other motivational, behavioural change methods is an important, emergent process.

Perhaps the most recent partnership example of coaching with health care is that of the Institute of Coaching; in 2009, the Institute became allied with the McLean Hospital, a Harvard Medical School affiliate, a fortuitous merger demonstrative of the perceived health impacts of coaching. There are numerous coaching training schools throughout North America each with their own method and techniques. However, most research using coaching as a treatment or intervention has not focused on a specific coaching method. Consequently, there is a discernible inability to assess the reliability and validity of the

generic use of "coaching" as a treatment or intervention for any behaviour change. Over the past two years, three studies assessing coaching's impact on obesity (Newnham-Kanas et al., 2008; van Zandvoort, Irwin, & Morrow, 2008; 2009), one on physical activity (Gorczynski, Irwin, & Morrow, 2008), and one on smoking cessation (Mantler, Irwin, & Morrow, 2010) have evaluated one specific method of coaching, that of Co-Active coaching (the form of coaching taught by the International Coach Federation-accredited Coaches Training Institute) as a treatment for behaviour change. The reported results of these studies attest to the utility of this particular coaching paradigm in effecting powerful health behaviour changes.

The purpose of this paper is to explore the unique qualities/characteristics/components of Co-Active coaching (hereafter referred to as coaching) compared to Motivational Interviewing (Miller & Rollnick, 2002) and Egan's Skilled Helper Model (SHM) (Egan, 2006). Motivational Interviewing (MI) was selected for comparison with Co-Active coaching due to our perception of their similarities, and expressed interest by health professionals who have shared with us their inability, to date, to define the difference between MI and coaching and/or have experienced difficulty applying MI's principles (also see Mesters, 2009). Upon submission of a recent manuscript that utilised Co-Active coaching as a treatment, one reviewer highlighted the overwhelming similarities between coaching and Egan's SHM (Egan, 2006). Our own work using the Co-Active model along with MI has led us to explore the commonalities of these change processes. By comparing and contrasting these behaviour change approaches, this analysis seeks to create clarity via a newly-derived model of *motivational coaching* that amalgamates the central threads from Egan's SHM, the MI principles, and the Co-Active coaching method. While there is not a substantial body of literature pertaining to the explicit use of Egan's SHM, our experience as researchers and coach practitioners suggests considerable merit in the elements and principles inherent in Egan's SHM. Our experientially and research grounded perspective is that coaching works quickly and powerfully; clearly, practitioners who utilize MI and Egan's SHM along with researchers who have assessed their effectiveness would attest to their important impact as well (references and study summaries are presented in the *Coaching, MI, and Egan's model/method Effectiveness* section below). Health practitioners – dieticians, nurses, nurse practitioners, diabetes' educators, and nutritionists among many other health change professionals – are in need of potent techniques that can be employed to motivate their clientele toward impactful, healthful behaviour change (e.g. Goldberg & Gournay, 1997). This paper provides a synthesis of the three models/techniques in order to close the gap on this practical need on the part of health care practitioners.

Method

Motivational Interviewing (Miller & Rollnick, 2002) and Egan's SHM (Egan, 2006) were compared to coaching descriptively with the following six questions guiding the comparison's components:

- How is the therapeutic alliance created; what is the purpose of the alliance?
- How is the client perceived by the coach/counsellor?
- How is the agenda determined for individual coaching/counselling sessions?
- How is each method/model sensitive to the needs of the client; in short, in what way/s is the method/model client-centered?
- What aspects of the client's lived experiences are involved in the coaching/counselling session?
- What process is used by the coach/counsellor to assess the client's need and/or readiness for change?

These six questions have been addressed in the written explanation of the three models/methods (below) providing clear points of reference for the comparison between coaching and MI and coaching and Egan's SHM. The following primary sources were used for describing the models/method presented throughout the paper: Egan, 2006; Miller and Rollnick, 1995; 2002; and Whitworth, Kimsey-House, and Sandahl, 1998; 2007.

In service of transparency, it should be noted that while the authors of this review are doctorally trained in health sciences, we also received supplementary coaching training through The Coaches Training Institute (CTI). The authors have previously conducted research assessing the effectiveness of Co-Active coaching as a behaviour change treatment (e.g. Newnham-Kanas, Irwin & Morrow, 2008; Gorczynski, Irwin, & Morrow, 2008; Mantler, Irwin, & Morrow, 2010; van Zandvoort, Irwin, & Morrow, 2008; 2009). We also want to note that there has been no collaboration, sponsorship, or professional affiliation with CTI.

Each model/method is described briefly and there follows an introduction to current research using each model/method as a behaviour change treatment. A discussion concerning the similarities and differences of MI and Egan's SHM compared to coaching is provided and amplified by summary Table 1. The concluding comments include a derivative model incorporating the functional features from each of the three models.

Table 1 - Comparison Among Techniques Utilised by MI, Coaching, and Egan

Model/Method	Motivational Interviewing	Co-Active Life Coaching	Egan's Self-Helper Model
Therapeutic Alliance	In MI, motivation can arise from the interaction between two people. The client is viewed as an expert and the counsellor is viewed as a catalyst in accelerating change by aiding the client in clarifying their reasons for change and helping them create a change plan.	Referred to as the Designed Alliance whereby the coach and client create a relationship that fits their working and learning styles and is respectful of the communication approach that works best for them. The coach is viewed as the catalyst for change and the power of coaching is in the designed alliance.	The client and counsellor alliance is co-constructed by the client and counsellor. Egan believes that change is facilitated through the relationship itself, the work that is done, and the outcomes that are achieved.
View of Client	It is presumed by counsellors that the client is able to increase intrinsic motivation and provide solutions to serve his/her own goals and values in order to facilitate change.	Coaching is based on the fundamental principle, from the coach's point of view, that nothing is wrong with the client and that the client is neither broken nor in need of fixing but is *naturally creative, resourceful, and whole* (NCRW). Clients are recognized as being the person who knows what is best for them and have the answers or are capable of finding the answers they need.	Counsellors do not view their clients as victims but as equal contributors that influence the process of their change.
Agenda Selection	Determined by the client	Determined by the client	Determined by the client
Aspect of client's life involved	Focused on specific aspects of a client's life. Impact of change on the client's whole life not stressed.	Involves client's whole life.	Involves client's whole life with specific emphasis on socio-cultural influences.
Flexibility of coach/counsellor	Counsellors move with their clients and in order to maintain positive therapeutic outcomes, counsellors must "roll with resistance" rather than challenge	"Dance in the moment" refers to the flexibility and willingness of the coach to go in the client's direction to meet the needs of the client. It involves listening at a very deep level to	Egan's model provides great flexibility for counsellors to move with clients depending on the moment.

	it. Resnicow and colleagues (2002) stated that MI is more like a dance rather than a wrestling match.	determine what is most important for clients based on their agenda.	
Process used to facilitate change	Two phases: 1) Building motivation for change; and 2) Strengthening the commitment to change.	Three principles: 1) Fulfillment; 2) Balance; and 3) Process.	Three stage model: 1) What's going on; 2) What solutions make sense for me; and 3) How do I get what I need or want.
Listening	Referred to as reflective listening. The key to this technique is how the counsellor responds to what clients say. The essence of this form of listening is about making a guess as to what the client really means.	Includes three levels of listening: Level I – coach's internal dialogue Level II – focused listening on the client Level III – wide range of listening that picks up on clients' emotion, body language, and the surrounding environment.	Empathic listening is used in the Egan model and focuses on attending, observing, and listening to the client – a way of "being with" the client. Egan contends that this form of listening is driven by the value of empathy and is a way for the coach to get inside the client's world. In this model, the counsellor's internal dialogue is referred to as the "internal conversation" of the counsellor.
Self-Management	MI counsellors work diligently to self-manage by reconnecting with clients if they slip into their internal dialogue. Counsellors will provide advice if it is requested or permission is granted by clients and it is viewed as aiding clients to meet their goals.	Self-management is about awareness and recovery. It is the role of coaches to become aware of when they are distracted and it is their responsibility to reconnect back with the client. Coaches manage the urge to provide opinions and advice in situations such as these in order to keep focus on what best serves the interest of the client. However, advice is provided if requested or in service of the client's goals.	Counsellors are constantly self-managing and are actually aware of when their own thoughts, feelings, or judgements have been triggered by something the client has said. Advice giving is viewed as robbing clients of self-responsibility. Therefore, counsellors do not set out to provide opinions and/or advice unless it is in service of or requested by the client.
Intuition	Based on reflective listening, the counsellor's intuition is essential in determining what the client really means. It is not implicitly stated or defined in MI, but based on the coaching definition, it is present in both phases. The counsellor's intuition is imperative in determining whether the client is ready to move from phase I to phase II of the MI method. A client may not always be aware of whether they are capable of making the leap into action – counsellor intuition and expertise are heavily relied on during this transition.	A coach's *intuition* is incredibly valuable to the coaching relationship. When coaches are able to fully trust their intuition, it provides an opportunity for clients to explore ideas, thoughts, and feelings that may not have been conscious to the client. By experiencing the coach's intuition, clients may in turn connect with a greater awareness to their own intuition.	Egan's model, like coaching, relies heavily on the counsellor's intuition. In Egan's model, intuition is viewed as a form of self-consciousness and refers to it as a virtual *second channel*. This second channel provides information to coaches on their own nonverbal behaviour, feelings, and emotions.

Findings

Model/Method Summary

Co-Active coaching - The Co-Active model (Whitworth, Kimsey-House, and Sandahl, 1998; 2007) graphically depicts the essence of the coaching training delivered by its creators. The *Co-Active* portion of its title refers to the collaborative interaction between coach and client based on the assumption of strength and capability of the client to determine what is best for him or her. It is a directed and structured *conversation* because it is emboldened by respect, openness, compassion, empathy, and authenticity on behalf of the coach and client. The coach's role is to empower clients to make choices based on their values; to hold clients accountable for their decisions and actions; and to support clients either in self-learning and/or moving forward towards their goals. This model uses three life principles as forms of coaching; the structure utilised is dependent on the client's needs. Fulfilment coaching is used to explore what it means for each client to live true to his/her values (fulfil those values) in his/her life; balance coaching is selected to provide alternative perspectives on recurring issues (ones where the client is stuck or overwhelmed) and to develop potential, planned, alternative courses of action to which a client can commit; and process coaching is chosen to address the internal emotional experience of the client and what is happening within him/her in the way s/he experiences life at the present moment in time.

Motivational Interviewing - Motivational interviewing (MI) represents about a quarter century of an interview style that is designed to resolve client ambivalence in service of moving toward change (Arkowitz, Westra, Miller, & Rollnick, 2008). Historically this is a significant paradigm shift from other counselling techniques. MI focuses on the behaviour of the counsellor as a key element in creating a relationship within which clients can accomplish change easily. The core of learning in MI is represented in this particular focus. MI is considered more of a style of therapy grounded on a set of principles (express empathy, develop discrepancy, roll with resistance, and support self-efficacy) rather than a set of particular techniques (Miller & Rollnick, 1995). As a definition, MI's founders state that it is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p.25).

Motivational interviewing is characterized by the following seven key points (Rollnick & Miller, 1995):

1) change must be elicited by the client and not imposed by the counsellor;
2) clients are responsible for articulating and resolving their own ambivalence;
3) counsellors do not persuade their clients to resolve ambivalence;
4) counsellors generally take a gentle approach that elicits change from clients;
5) counsellors are focused in helping clients examine and resolve ambivalence;
6) readiness to change fluctuates depending on the interpersonal interaction between counsellor and client;
7) the counsellor/client relationship is a partnership where the counsellor respects the client's autonomy.

The founders of this method (Miller and Rollnick) have conceptualized the MI process in two phases. Phase I centres on building motivation for change. Some clients enter counselling already convinced that there are multiple reasons to change. These clients may have little use for Phase I except to clarify those reasons from the client's perspective. Clients who are not as clear about their reasons for

change first must determine how important change is to them as well as their confidence that they can actually make the changes needed to meet their desired goals.

Phase II focuses on strengthening the commitment to change. This phase is entered when clients have reached a point of readiness, itself the essence or *sine qua non o*f MI, and the counsellor recognizes that change should be initiated. Clients are expected both to elicit and be explicit about what they want and plan to do. This change plan involves: 1) setting goals; 2) considering change options; 3) arriving at a plan; and 4) obtaining commitment. Commitment to a change plan concludes the cycle of MI. This method is a style of counselling and psychotherapy which stems from a flexible approach that can be used on its own, in conjunction with another approach, or as an adjunct to another therapy (Arkowitz et al., 2008).

Table 2 - Background Comparison of the Three Models ~ MI, Coaching, and Egan's SHM

Model/Method	Motivational Interviewing	Co-Active Life Coaching	Egan's Self-Helper Model
Founders	Dr. William R. Miller and Dr. Stephen Rollnick	Laura Whitworth and Karen and Henry Kimsey-House	Dr. Gerard Egan
Year Developed	1983	1992	1986
Training Required	There is not a standardized training package or training requirement to be considered a Motivational Interviewer. Training programs that are offered varying in the number of days and hours involved in training. This form of training does appear to be geared towards health professionals.	Prerequisites for certification include completion of the first four Co-Active core coaching courses – Fundamentals of Co-Active coaching, Fulfillment, Balance, and Process. Certification includes the completion of a six-month certification program offered by the Coaches Training Institute along with an established relationship with a Certified Professional Co-Active Coach (CPCC), a Professional Certified Coach (PCC) or a Master Certified Coach (MCC) from the International Coaching Federation. After successful completion of the program students are eligible to take the written and oral certification exam. Any individual regardless of their previous training or occupation may apply for the course work and certification program.	There is not a standardized training program for Egan's Helper Model. Some universities offer this training as part of their psychotherapy or counsellor curriculum. For example, the Kelowna College of Professional Counselling in British Columbia offer a number of courses in their program that emphasize solution focused modalities and the works of Egan are used in some of the curriculum. The UK College of Holistic Training offers a certificate in Skilled Helper Counselling and an online coaching program that is available to international individuals. The program lasts anywhere from one to three months. Egan training does appear to be geared towards individuals enrolled in a counselling program. However, programs do exist without any prerequisites.
Primary Goal	To elicit behaviour change by helping clients to explore and resolve ambivalence (Miller & Rollnick, 1991).	To assist clients in creating the life they want by forwarding the action and deepening the learning through discovery, awareness, and choice (Whitworth, Kimsey-House, & Sandahl, 2007).	To aide clients in managing their problems in living more effectively and develop life-enhancing un-used opportunities more fully (Egan, 2006).

Egan's Skilled Helper Model (SHM) - Egan's SHM (Egan, 2006) is described as a client-centered and systematic approach to 'helping'. It is typified more as a framework for conceptualizing the helping process than a theoretically-derived model. Metaphorically, Egan's SHM is compared to a map in that the map helps the skilled helper to know where to go with a client; the intended goals of the model are to help people become better at helping themselves in their everyday lives and/or manage their problems in living more effectively and develop unused opportunities more fully. The role of clients is to commit themselves to the helping process and capitalize on what they learn from the helping sessions to manage the challenges

of their life more effectively. The model emphasizes empowerment and consists of three stages each with its own fundamental question for clients to consider: 1) what's going on?; 2) what solutions make sense for me?; and 3) how do I get what I need or want? Within each stage, specific tasks are provided to answer the underlying questions but these tasks are not restricted to the stage under which they are described. In stage I, clients are provided with the opportunity to share their story. This creates an opportunity for the counsellor to work with the client to develop new perspectives and reframe his/her story. In stage II, counsellors help clients discover possibilities that will lead to a clearer future; and stage III is geared towards action. Egan's SHM has undergone a variety of iterations (1975; 1982; 1990; 2006); within this paper, coaching will be compared to its most recent version (2006). Table 2 above provides key comparative and background information regarding each model/method.

Coaching, MI, and Skilled Helper Model/Method Effectiveness

As mentioned in the introduction, life coaching is a relatively new area of research with respect to its application in the health field. Over the past two years, four studies have evaluated and reported the effectiveness of Co-Active coaching as a behaviour change treatment in the areas of obesity, physical activity, and smoking cessation (Newnham-Kanas, Irwin & Morrow, 2008; Gorczynski, Morrow & Irwin, 2008; Mantler, Irwin & Morrow., 2010; van Zandvoort, Irwin, & Morrow, 2008; 2009). Although coaching research is in its infancy, MI has been used for several years as a successful intervention in research with a specific emphasis on addictions or addictive behaviours primarily associated with alcohol use (Brown & Miller, 1993; Miller, 1998; Miller, Yahne, & Tonigan, 2003). However, more recently, MI has been utilised to address health behaviours and conditions with continued success in areas such as: smoking (Butler, Rollnick, Cohen, Bachman, Russell, & Stott, 1999); diet (Berg-Smith, Stevens, Brown, Van Horn, Gernhofer, Peters, et al., 1999); physical activity (Harland, White, Drinkwater, Chinn, Farr, & Howel, 1999); medical screening (Taplin, Barlow, Ludman, MacLehose, Meyer, Seger et al., 2000); diabetes control (Doherty, Hall, James, Roberts, & Simpson, 2000); and medical adherence (DiIorio, Resnicow, McDonnell, Soet, McCarty, Yeager, 2003). Similar to MI, Egan's SHM has been applied to specialist client populations and contexts with reported success with: sexual abuse (Hall & Lloyd, 1993); student counselling (Stein, 1999); counselling primary health care (Hudson-Allez, 1997); and training nurses and other health professionals (Arnold & Boggs, 1995; Freshwater, 2003). Despite the fact that Egan's SHM has been used with specialized populations, there was no research located that sought to assess its effectiveness specifically as a behaviour change intervention (Egan's SHM is primarily cited as a viable treatment method in textbooks and handbooks that are aimed at treating specialized populations such as victims of sexual abuse). The results from studies that assessed coaching's and MI's findings regarding behaviour changes are summarized in Table 3 below.

Table 3 - Summary of Study Results Utilizing MI, Coaching, or, Egan in Health Behaviour Interventions

Authors	Year Published	Participants	Results
Berg-Smith, S. M., Stevens, V. J., Brown, K. M., Van Horn. L., Gernhofer, N., Peters, E. et al.	1999	Youth and adolescents (13-17 yrs) dealing with dietary issues.	Overall, the intervention successfully re-engaged participants in personalized goal setting, and appeared to increase and renew adherence to the DISC dietary guidelines.
Butler, C.C., Rollnick, S., Cohen, D., Bachman, M., Russell, I., & Stott, N.	1999	Cigarette smokers (28-55 yrs).	Significantly more patients in the motivational consulting group reported not smoking in the previous 24 hours (P = 0.01), delaying their first cigarette of the day more than five minutes after waking (P = 0.01), making an attempt to quit lasting at least a week during follow-up (P = 0.04), and being in a more ready stage of change (P = 0.05).
DiIorio, C., Resnicow, K., McDonnell, M., Soet, J., McCarty, F., Yeager, K.	2003	Women with HIV.	Mean scores on ratings of missed medications were lower for participants in the intervention group than those in the control group. Although there were no significant differences in the number of medications missed during the past 4 days, participants in the MI group reported being more likely to follow the medication regimen as prescribed by their health care provider.
Doherty, Y., Hall, D., James, P.T., Roberts, S.H., & Simpson, J.	2000	Health care workers.	This was a feasibility study that examined whether skills in counselling behaviour change may help staff working in diabetes care to facilitate self-management in people with diabetes. The findings suggest that the stages of change model, motivational interviewing and behavioural techniques are relevant to work in this area.
Gorczynski, P., Morrow, D., & Irwin, J.D.	2008	Inactive youth (12-14).	Physical activity increased for one participant while the other participants' physical activity remained unchanged. No significant changes occurred in self-efficacy, social support, and perceived behavioural control with specific regard to becoming more physically active.
Harland, J., White, M., Drinkwater, C., Chinn, D., Farr, L., & Howel, D.	1999	Adults (40-64 yrs)	More participants in the intervention group reported increased physical activity scores at 12 weeks than controls (38% *v* 16%, difference 22%, 95% confidence interval for difference 13% to 32%), with a 55% increase observed in those offered six interviews plus vouchers. Vigorous activity increased in 29% of intervention participants and 11% of controls (difference 18%, 10% to 26%).
Miller, W.R., Yahne, C.E., & Tonigan, S.J.	2003	In- and outpatients entering public agencies for treatment of drug problems.	Contrary to prior reports, MI showed no effect on drug use outcomes when added to inpatient or outpatient treatment, although both groups showed substantial increases in abstinence from illicit drugs and alcohol.
Newnham-Kanas, C., Irwin, J.D., & Morrow, D.	2008	Obese adults (35-55).	Significant decreases in waist circumference (p = 0.032) and increases in self-esteem (p = 0.01) and functional health status (p = 0.01) were found. Qualitatively, participants reported an increase in daily physical activity and healthier dietary choices feelings of optimism, and greater self-acceptance.
van Zandvoort M., Irwin, J. D., & Morrow, D.	2009	Female university students (17-24 yrs)	At the conclusion of the study period, participants attributed enhanced self-acceptance; living healthier lifestyles; and making themselves a priority to their coaching experience. They appreciated being treated as the expert in their lives.

Similarities and Differences Among the Models/Methods

How is the therapeutic alliance created; what is the purpose of the alliance? Similarities and differences exist when considering the therapeutic alliance for MI and coaching. Both methods view the client as expert and assert that the power of the coaching/counselling relationship enables change to take place for the client. In MI, the first session involves establishing the fundamental ground rules and administrative procedures, exploring the current state of the client, and designing what the future looks like for clients. All of these features are similar to those employed in coaching. However, in MI, there is not a mutual responsibility to define and design the counselling relationship. Clients are not involved in determining how they are going to be counselled. For example, the counsellor does not inquire whether clients want homework, how they want to be held accountable, or if they would prefer a gentler counsellor or one who is more direct. In addition, more emphasis is placed within MI on the counsellor's role than is the case with coaching's reliance on the client's ability to make changes in his/her life. In coaching, if resistance appears, the coach views this as an opportunity to explore what is behind that resistance with emphasis on the client's experience of resistance. In MI, if resistance increases within the client, it is viewed as a problem in the interpersonal context between client and counsellor; in fact, within MI, resistance is perceived as a clear indicator of lack of readiness on the part of the client. Specifically, in MI, perceived resistance is more attributed to the counsellor's style of counselling, not to anything about the client. Readiness is the key variable in the change process within MI. While the apparent difference in this readiness feature might point toward coaching's more client-empowered approach to the collaborative relationship between coach and client, it also might reflect the semantics of the MI approach in not pushing past client readiness.

The designed alliance between client and counsellor inherent within the Egan SHM aligns directly with the Co-Active model in that the alliance is co-constructed by the client and counsellor/coach and is usually established within the first few sessions. Egan, like the founders of the Co-Active model, place special emphasis on the importance of the therapeutic/designed alliance in fostering change.

How is the client perceived by the coach/counsellor? The most fundamental aspect of all three models or methods is the reliance on asking questions of the client versus providing answers, advice, or solutions for the client. The most impactful questions are those that are open-ended ones that invite the client to explore and experience *what* is happening with him or her rather than analyze or assess *why* and/or *how* events or issues are affecting them. Thus, the most potent questions tend to be ones like, *what is important about _____ to you? What is _____ like for you? Say more about _____*. Part of the power in asking questions comes from how the client is perceived by the coach or counsellor. Coaching is based on the premise, from the coach's point of view, that nothing is wrong with the client and that the client is neither broken or in need of fixing. Instead, in coaching (CTI) terminology, the client is perceived as *naturally creative, resourceful, and whole*. The coach's primary role is to ask open-ended questions that invite discovery, learning, and potentially, change. By asking powerful questions, the coach assists clients in discovering how well they know themselves, their strengths, and their limitations. By answering the questions posed by the coach, clients are able to uncover what they know to be true about themselves, that is, they are encouraged to and can articulate and do know what they want, what they fear, what motivates them, their vision, and their purpose. When clients create their own answers, their solutions are more adhesive, resourceful, and effective, thereby often resulting in a higher level of commitment to change. This enables and empowers clients to follow through with action in the direction of their desired change.

Within the underlying spirit of MI, the term autonomy highlights the importance of the client taking responsibility for his/her change. It is assumed that the client is *creative* and *resourceful* with an individual ability to increase intrinsic motivation and provide solutions to serve his/her own goals and values in order to facilitate change. Even though MI traditionally has dealt with clients who have addiction issues, MI, comparable to the coaching model, does not subscribe to labels, such as alcoholic. MI deals with client behaviours and avoids clinical terms that may take away from, compartmentalize, or minimize the subjective experience.

Coaching's basic premise that the client is naturally creative, resourceful, and whole again aligns very closely with the Egan model. The fact that Egan's model focuses on partnered learning – the "skilled helper" in the model's ascription – and, comparable to both coaching and MI, Egan uses the term 'client' instead of 'patient.' This highlights the important feature within all three models that clients are not perceived as needing to be fixed; instead, clients are seen as agents of change in their own lives. Egan's SHM endorses the findings of Bohart and Tallman (1999) regarding the self-healing nature of clients. That is, clients are the experts in their lives and by viewing clients as anything less deprives them of the full client-centered experience and subsequent learning that may ensue. However, Egan does deviate from MI and coaching by using the term "healing;" this may imply a grounding of the theory in the therapeutic tradition or a semantic notion of healthy behaviour change.

How is the agenda determined for individual sessions? The client in a coaching relationship determines the agenda, not the coach. This cornerstone of the Co-active coaching highlights that coaching is centred on achieving the results clients' want. The coach's role is to hold the overall or main agenda determined during the designed alliance wherein the client specified what s/he wanted from the coaching experience (e.g. to lose weight and increase physical activity). By assuming responsibility for maintaining the client's agenda, the coach makes certain that the client is always working towards fulfillment and balance and is experiencing fully the process of one's life even while exploring 'smaller' agendas (being late for work, having a squabble with a family member) in individual sessions.

Counsellors using MI believe that having the client set the agenda facilitates active participation in the counselling process and supports their belief in the autonomy of the client. At first glance, MI seems focused and goal directed towards the resolution of ambivalence. This might raise the question of whether the agenda actually comes from the client. However, it could be argued that clients seeking coaching are also in a state of fluctuation with the inability to make choices. Therefore, MI and coaching do align with respect to agenda determination.

Egan's approach and that of coaching are a little more obvious in their similarity regarding who determines the agenda for the session. One of the key values in the skilled helper model is that of keeping the client's agenda in focus. Emphasis is placed on the client's agenda and not what the counsellor thinks the agenda should be for the client. There is absolutely no apparent difference between the Egan and the coaching model in this regard.

How is each method/model sensitive to the needs of the client; in short, in what way/s is the method/model client-centred? Coaching sessions often involve constant shifting of themes and topics depending on the client's responses to questions posed by the coach; client and coach are said to *dance in the moment*. Dancing in the moment refers to the flexibility and willingness of the coach to change conversational direction to meet the needs of the client, while always maintaining a focus or connection to

the larger client-defined agenda. This aspect of the coaching model involves listening at a focused level of awareness in order to determine what is most important for clients based on their overall or main agenda.

The notion of dancing in the moment is not stated explicitly in the MI method. However, its inherent existence is evident when resistance surfaces in the client. In order to maintain positive therapeutic outcomes, counsellors must "roll with resistance" rather than challenge it (Resnicow, Dilorio, Soet, Borelli, Hecht & Ernst, 2002, p.445). Resnicow and colleagues (2002) stated that MI is more like a *dance* rather than a wrestling match between counsellor and client – a feeling of compliance and ease with the dance than the more frustrating sense of wrestling against a client. Also, this dance aspect is visible when one considers how the counsellor holds the client's agenda while following the client as the counsellor leads them in the direction that is most suitable to her/his needs. Similar to coaching, the client is the real lead in this dance.

Although Egan's SHM may appear as rigid because it involves sequential stages that must be followed, it provides considerable flexibility to move with clients depending on the issue under discussion at any given moment; the 'map' in the Egan SHM is malleable. It is not assumed that each client will need to begin at stage I or that a client who has completed stage II cannot return to stage I if needed. Comparable to both MI and coaching, Egan counsellors move *with* their clients in order to meet the clients' needs.

What aspects of the client's lived experiences are involved in the coaching/counselling session? As the coaching process evolves, change experienced by clients permeates into all aspects of their life; this is the reason that coaching involves *addressing the client's whole life*. The coaching model recognizes that the agenda that clients bring to their coaching session often will impact other parts of their lives. In the same way that the body's fascia tissue is completely interconnected – such that a change in the integrity of fascia in one area of the body impacts a seemingly disparate region of the body – so too does a seemingly unrelated aspect of a client's life impact their overall or whole life. Although individual sessions may address one issue that involves one particular component of a client's life, the choices made move the client towards creating a whole life that is more fulfilling, achieves better balance, and/or embodies a more successful life process.

The client's whole life is not explicitly highlighted as an important aspect of the MI method. This method of helping is a form of focused or guided counselling. When MI counsellors explore the advantages to change, other aspects of the client's life may emerge. Therefore, the awareness of how changes will impact other areas of the client's life is not overtly stressed in MI but seems implicit in the notion of enhancing intrinsic motivation to change by exploring and resolving ambivalence.

The Egan SHM addresses the client's whole life in a similar way to that of coaching. Moreover, the Egan SHM pays considerable attention to the socio-cultural settings in which the individual is experiencing life and/or will experience in his/her life. This includes different stages of human development, cultural influences, large institutions (e.g., government, organized religion), and personal settings (e.g., family, friends, work, etc.) (Wosket, 2006). Thus Egan's model is sensitive to whole life as environmental context.

How does the coach/counsellor address the client's reason for seeking help? Whitworth and colleagues (2007) state that the foundation of coaching is based on a belief in three key, interactive life principles – *fulfilment*, *balance*, and *process*. These, in turn, encapsulate what is referred to as the three core principles of the Co-Active model. The Co-Active style of coaching is predicated on the coach knowing

from which life principle or coaching style s/he should access in order to serve the needs of each client in the best fashion.

Clients often seek coaching to address their longing for a feeling of being truly alive and complete. *Fulfillment* coaching is designed to assist clients in envisioning and moving toward a more gratifying life or lifestyle. Clients know that they are not living a life that is a true reflection of who they are and are looking toward the coaching process to help determine what will fill their heart and soul. This principle creates an opportunity for clients to discover and clarify their *values* in order for coaches to challenge clients to live a fulfilling life based on or in line with their values. Indeed, within coaching, values are regarded as the lights illuminating each client's path of fulfilment. Coaches use a number of practical ways to help their clients identify and clarify their personal definition of fulfillment. These may include: exploring clients' level of satisfaction in their life by using a 'wheel of life' representation of their values and other tools to determine areas that need improvement; determining whether clients are honouring their values in the decisions they make; helping clients envision their desired or 'future' self; co-creating an alluring or compelling life purpose; and investigating the different forms of dissonance that may arise when values are not being honoured.

The *balance* principle is a dynamic style of coaching used to explore additional opportunities and perspectives that clients are unable to see on their own. When clients are stuck in a particular perspective (the way it is, or, reminiscent of the often hyperbolized definition of insanity as the process of doing the same thing over and over again but expecting different results) the coach can utilize the balance style of coaching to move the client from a position of inertia/stuck-ness to one of being able to explore and evaluate possibilities leading to action. The coach and client work together to identify the current perspective of the client and to explore new perspectives. The development of new perspectives creates an opportunity for the client to realize he/she is in a position of choice and is actually capable of shifting to a new perspective. The concept is to focus on how to manage a life situation in a less stressful or onerous way rather than trying to change the situation. For example, for a client dealing with a difficult family member, the situation is likely not addressed best by trying to change the family member; instead, working toward changing the client's perspective on being with that family member can yield dramatic results. Once a choice of perspective has been made, the coach and client brainstorm ways to make the new choice a reality. Finally, the coach and client determine ways for the client to commit to this new choice and a concomitant plan of action. Subsequent coaching sessions might be used to refine the plan of action; however the action plan itself is initiated outside of the coaching sessions *per se*.

Whereas fulfillment and balance are concerned with action, the *process* principle involves the internal, emotional experience of the client in the present moment of his/her life. Process coaching provides the client with an opportunity to slow down and become aware of the experience that is going on in his/her life. It is believed that through the process principle, clients learn to be present in their life with a view toward guiding them to greater awareness. The impact of process coaching often results experientially in richer highs and stronger lows in a strong assumption that this process can lead to a life that is fully experienced. There are five steps in the process pathway: 1) the coach hears the life disturbance or "turbulence" and names it; 2) the coach explores it with the client; 3) the client experiences it; 4) a shift occurs, and the client integrates it; and 5) movement happens. Process coaching allows clients to explore in the present moment the positive and negative emotions they experience.

The MI method is primarily concerned with changing a particular issue, such as alcohol abuse, and not specifically with helping clients live a more fulfilling life. Although feelings of being alive and

complete may result from a change in behaviour, it is not a fundamental principle or objective of the method. Instead, for change to take place, the client needs to become aware of the discrepancy between his/her own experiences and *values*. It is through the exploration of values that the coaching model and MI share common aspects of coaching's fulfillment principle. Miller and Rollnick (2002) devote an entire chapter to the important role of values in MI counselling especially utilizing the MI principles of client empathy and developing discrepancy (the latter refers to revealing awareness between current behaviour that is not aligned with broader values). The technique of reflective listening is particularly important in this exploration as counsellors use this skill to demonstrate empathy, affirm client thoughts and feelings, and help clients continue through the discovery process. In MI, reflective listening sets the foundation for the action established in phase II. With respect to fulfilment and values, one commonality between coaching and MI is the use of envisioning the client's future self. This is a form of change talk that the counsellor applies during counselling sessions to help clients visualize what change would look like from their perspective. Like a coach, the MI counsellor encourages the client to view the future without judgment or worry of how that vision will be attained.

An MI counsellor, like a Co-Active coach, holds the client's overall agenda while moving the conversation in a direction of action thereby ensuring that the action aligns with the client's values. While a visual representation of the client's whole life is not employed in the MI method, as it is in the coaching model, a like-minded rating scale often is used to determine a client's confidence regarding a given task and the client's perceived level of importance of that task to his/her life – the same technique as coaching but with an intention that is anchored, within the MI framework, in client readiness for change.

The notion of balance (the principle of balance in the coaching model) is considered the core principle of the MI method and is used in both phases of the treatment plan. The similarities between both methods are strikingly apparent in this principle. In the second phase of MI, the steps involved in negotiating a change plan closely resemble the steps in coaching's balance 'formula'. The comparable balance coaching principle and the MI second phase of negotiating a balance change plan are summarized in Table 4. The first step in MI (setting goals) encompasses the *perspective* and *choice* stage in the coaching model. Specifically, it is imperative that counsellor and client determine what perspective the client is currently inhabiting in order to determine the discrepancy between the client's goals and his/her present state. Although multiple perspectives are explored in MI, they are concerned with advantages to change and/or disadvantages to the status quo – exploring advantages of the status quo in the MI method are not encouraged as they do not elicit change talk or aid in increasing intrinsic motivation to change.

The second stage in the MI method aligns with the *planning* stage in the coaching model. Herein, clients explore ways to achieve their goals. Brainstorming is a key aspect of this stage and clients are encouraged to provide as many options as possible without judgment or fear of being unable to produce the desired goal. At the end of this stage, clients are able to choose a possible behaviour that aligns with their values.

The third stage (arriving at a plan) of the MI method parallels the *commitment* stage of the balance principle. The counsellor and client formulate a plan that addresses the client's goals, needs, intentions, and beliefs. In the final stage (eliciting commitment), commitment is determined and the client has a clear plan to follow. It is also a stage where clients can determine in whom they will confide to honour their commitment to change. Like the coaching model, MI clients initiate action outside of the counselling session. Although the coaching model has a fifth stage (action), this phase is implied in the final stage of the

MI model. Clients are encouraged to stay in contact with their counsellor to monitor progress. Table 4 below illustrates how the MI stages fit within the stages outlined in the balance principle:

Table 4 - Balance coaching compared to MI stages of balance method

Co-Active Coaching	Motivational Interviewing
1) Perspectives 2) Choice	1) Setting goals
3) Planning	2) Considering change options
4) Commitment	3) Arriving at a plan
5) Action	4) Eliciting commitment

The process principle is not evident in MI even though certain techniques that mirror process coaching are often utilised. For example, MI works with clients in the present moment but not with the intention of slowing down and becoming aware of their internal emotional experience. Instead, as always in MI, the purpose is to explore client readiness. Process coaching techniques are predominately used in phase I on the MI method. Four methods from the MI model are used frequently to move the client towards change; these methods resemble the steps used in process coaching: affirming; reflecting; summarizing; and eliciting change talk.

Coaches will use level III listening (described in Table 1), which is diffuse or situational listening, to name the turbulence (stage one in process coaching), whereas MI counsellors use reflective listening. The latter technique is considered one of the most important procedures in MI and the most challenging. It most closely resembles level II listening (full attention devoted on the client) in coaching with the added component of reflecting back to the client.

Affirming and supporting the client are ways to build rapport with the client in MI and facilitate open exploration. This is similar to the second step in the process coaching principle. The summary stage in MI is used to summarize and reinforce material that has been discussed. Eliciting change talk in MI integrates the fourth (a shift happens) and fifth (movement happens) steps of the coaching model. This is where resolving ambivalence starts to occur in MI. This stage is considered consciously directive and allows clients to present their arguments for change. Table 5 below demonstrates how the four methods in MI articulate with the stages outlined in the process principle of coaching.

Table 5 - Process coaching compared to MI stages of interviewing

Co-Active Coaching	Motivational Interviewing
1) The coach hears the turbulence and names it	Reflecting
2) The coach explores it	Affirming and supporting
3) The client experiences it	
4) A shift happens and the client integrates it	Eliciting change talk
5) Movement happens	

Given the traditional MI clientele (individuals with addiction issues), it is surprising that more emphasis is not placed on celebrating client achievements when change occurs, as a logical inference for an addiction treatment technique such as MI. This may be a result from clients not continuing on with a counsellor when change is initiated.

The Egan SHM, even with its stated goal of helping, encapsulates the essence of the fulfillment principle. There are similarities and slight differences in the tools used to help move clients to a more fulfilling life. For example, in coaching, the wheel of life technique (wherein client's life values are represented as pie-shaped wedges within a 'pie' circle) is frequently employed to underscore areas in the client's life that are not lived to the fullest extent possible. In the Egan SHM, the client's story is used as a way for clients to connect with their internal world, bringing attention to areas in their life that may or may not be fulfilled. It could be argued that the wheel of life is a more concrete tool for assessing clients' satisfaction with their life because it provides a visual representation of areas in need of change. As well, constructing the wheel offers something concrete for clients to which they can refer back in the future.

As in coaching, counsellors using the Egan SHM in stage I are encouraged to help their clients move away from current difficulties by imagining what the future could hold. According to Wosket (2006), this stage is about hope and renewing it within the client. As well, Egan counsellors, like coaches, are aware of and bring to the attention of the client when they are using different tactics to avoid the discomfort of dissonance. In the coaching model, dissonance is highlighted in the fulfillment principle but like Egan's SHM, it is omnipresent within the different coaching principles.

It is the balance principle in coaching that most resembles the three stages of Egan's SHM. The three stages of the Egan SHM consist of three tasks to help clients fully answer the question posed by that stage. Task 1 (possibilities) in stage II aligns with the first step (perspectives) in the balance formula. Here, the client works with the counsellor to generate many potential change possibilities in service of co-creating a better future.

Task 2 (change agenda) in stage II involves clients choosing which possibility appeals most to their quest for change in creating problem-managing goals. This step mirrors the second step of the balance formula (choice). In the Egan SHM, clients are encouraged to commit (task 3 in stage II) to their goal before the planning process (task 3 in stage III) can begin to achieve their goal. The reverse is true for coaching, planning precedes commitment.

Stage III of the Egan SHM mirrors the planning stage of the balance formula. Similar to coaching, the client's action takes place outside the coaching session. Asking clients how, when, where, and what regarding their plan often helps clients visualize the actions needed and leads to a greater likelihood of success (Wosket, 2006). Although the ordering of the different stages and tasks are different between these two models, all of the elements of Co-active coaching's balance formula are present in the Egan model. Table 6 below illustrates how the Egan stages compare to the stages outlined in the balance principle of coaching:

Table 6 - Balance coaching compared to the Egan SHM

Co-Active Coaching	**Egan's Self-Helper Model Stages**
1) Perspectives	S2T1) Possibilities
2) Choice	S2T2) Change Agenda
4) Commitment	S2T3) Commitment
3) Planning	S3T1) Possible strategies
	S3T2) Best fit
	S3T2) Plan
5) Action	Action

Note. S = stage; T = task.

The Egan SHM presents itself as an action-oriented method that may or may not allow clients to explore fully their emotional experience. Although this model appears this way, Egan contends that action may be in the form of a client extending his range of feelings. There is not a specified stage where present emotional experience is explored with clients. Instead, the model lends itself to this process in each of its stages depending on where the client is in the helping process. There are not prescribed steps for counsellors to follow to help a client through a particular experience as there are in the process principle of coaching. Table 1 presents a summary of the similarities and differences among the three models/method.

Conclusion

Throughout this comparison among Co-Active coaching and Egan's Self-Helper Model and Motivational Interviewing, similarities and differences are presented. What is glaringly consistent and distinctive is the overwhelming synonymy across the three methods. What then is the true value of coaching beyond its individual components and techniques given that it is so similar to a model and a method that have established roots in the behaviour change arena? Three main differences separate coaching from Egan and MI: who can become coaches/counsellors; training to become a coach/counsellor and the potential stigma associated with coaching versus counselling.

Individuals seeking training in Egan's SHM or MI are often health care professionals or individuals in the helping professions. Motivational Interviewing often refers to its trainees as clinicians and Egan's SHM is most frequently incorporated into a psychology or counselling program curriculum (Kelowna College of Professional Counselling in British Columbia; The UK College of Holistic Training). It is not a prerequisite that Co-Active coaches have any training in psychology or counselling. This can be and has been recognized as one of the shortcomings of coaching's perceived value as behaviour change intervention, even a scepticism that challenges its practitioners' scope of practice and professional qualifications. Even though Egan's background is in psychology, he contends that helping professionals who have received formal academic training, like graduate students in a clinical psychology program, do not necessarily produce effective, competent helpers (Egan, 1975). Carkhuff (1972) and Carkhuff and Berenson (1967) emphasize that the mastery of helping skills, is what is truly important in determining the effectiveness of the helper. In turn, credentials are not an indication of an excellent helper. Coaching then is disparate from MI and Egan's SHM in that most coaching schools unlike counselling training programs, inclusive of CTI, emphasize coaching skills acquisition without any attention to theory mastery or professional background of prospective coaches. At the same time, comparable to the work of Elder et al (1999) in explicating the theoretical and applied effectiveness of health-behaviour theories and models, so too has the Co-Active model been shown to be theoretically grounded (Irwin & Morrow, 2005). In terms of practical application, the Co-Active coaching and Egan model and their attendant skills are relatively easy to learn and provide a discernible, clear path toward working with clients to motivate them to make important changes in their lives. In response to previous criticism about the difficulty in applying MI principles (e.g. Mesters, 2009), the application-based tools offered within the Co-Active model and the Egan model may be used to put MI tenets into practice.

Additionally, perhaps one of the most important differences among these three behaviour change models/method is the negative stigma society has placed on the term "counselling" (Vogel, Wade, & Hackler, 2007). Counselling, which is often synonymous with the term therapy, is frequently associated with alleviating dysfunction (Sirey, 2008). This perception very much mirrors the prevailing health care trend and pervasive practice that focuses so strongly on treatment rather than prevention before or in

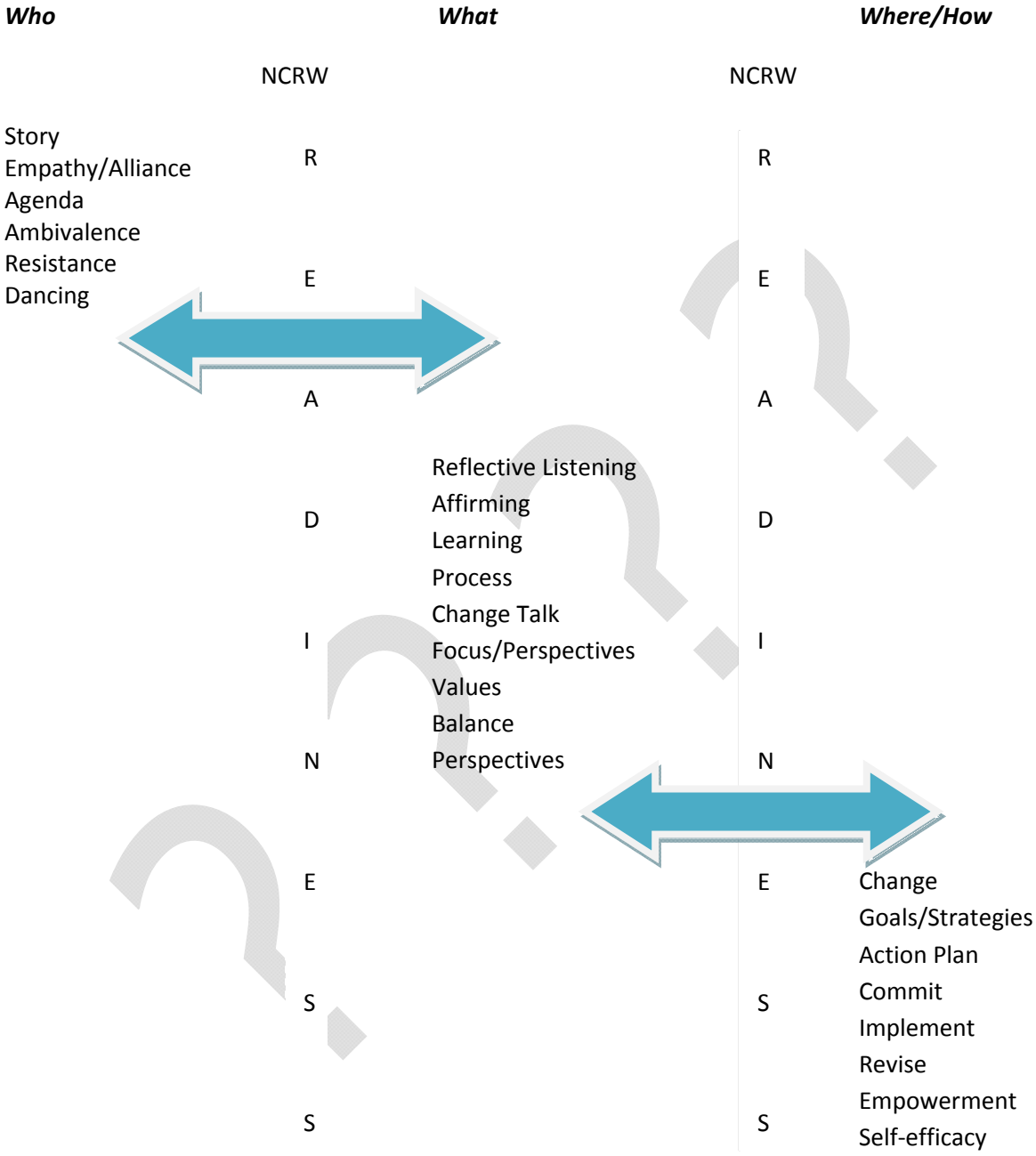
adjunct to treatment. The perceived social costs of being stigmatized for seeking counselling assistance often is a barrier to treatment participation, especially with men who utilize formal help less often than women (Sirey, 2008; Smith, Tran, & Thompson, 2008). Even Egan's SHM that regards clients as strong and able participants in the helping process, uses terms such as "healing" (2006, p.38) that can reaffirm a dysfunctional or less-than view of the client. Alternatively, life coaching is viewed as life enhancing and/or is used as professional development to improve performance (in executive coaching, for example).

As a result, businesses have incorporated life coaches into their professional development and human resources departments as accessible resources (termed "in-house" coaching) for their staff. This trend is underscored in Grant's annotated bibliography (2005). Although life coaching is still a behaviour change model, print media and television programs have popularized the term "life coach." As a result, coaching's stigma may be viewed as more socially acceptable and an individual's sense of normalcy may be maintained even though they are seeking help. As well, many life coaches use the telephone to connect with their clients thereby increasing confidentiality and accessibility to coaches around the world (to the best of our knowledge both MI and Egan's SHM are face-to-face practices). This has allowed people to secure the treatment necessary for issues such as emotional health (e.g. anxiety and stress), obesity, and attention deficit hyperactivity disorder (ADHD) without the fear of being isolated from their families and society and without the stigma of being "sick" or a "weirdo" or "loony" – terms often associated with people experiencing mental health problems (Putman, 2008, p.684). Life coaching has therefore opened the door for individuals to access confidently the assistance they need to lead a fulfilling and successful life.

Given the similarities among all three methods it cannot be said that any of them are necessarily unique in their core principles or tenets. Their uniqueness lies in the way that they are packaged and delivered. Coaching is unique in its grouping of core principles that form the foundation for its coaching techniques. In juxtaposing MI, coaching, and Skilled Helper models, what is clear is the overlap among these three important methods of behaviour change; most similar are the Co-Active coaching model and Egan's SHM. Whereas MI and the Skilled Helper methods or principles are embedded in counselling traditions/practices, Co-Active coaching has developed an applied or experiential framework that may be more readily applied than the more principle-oriented MI or the stage-encapsulated SHM.

Working with health professionals from a wide variety of sectors, the refrain we hear is the paramount need to motivate clients to make important health behaviour changes. Health professionals have a wealth of knowledge and experience; however, a real issue they face is the gap between a client knowing what they want and making the actual behavioural changes to get there. Closing that gap, resolving client ambivalence, and working with clients to motivate them to make changes is critical to health change. In service of more successful outcomes in effecting health behaviour change, what we have conceptualized in Figure 1 is a model of *Motivational Coaching* that is informed by this study's comparative analysis of the three models/method analyzed in this paper.

Motivational Coaching: An Integrated Model for Effective Health Behaviour Change



Our intent is to distil into one framework the key components of three overlapping methods used in working toward behavioural changes. The *Motivational Coaching* integrated model is a through-put framework with full feedback loops through/to each phase; that is, the phases – Who, What, Where/How – represent the process of *MC*, a process we envision as a spiral form rather than a linear one. The Figure might be better imaged as a revolving, vertical 3-D cylinder rather than a one-dimensional representation. At the core of the *MC* model are powerful, open-ended questions (represented by the watermark question-marks) that underlie every aspect of the model; learning to ask powerful questions is the primary skill that needs to be acquired and honed and applied throughout every phase of *MC*. Holding clients naturally creative, resourceful, and whole (NCRW in the model above) is fundamental to the *MC* process as is the facilitator's vigilance for all indicators of readiness for change. The *Who* phase (*who* is my client in the fullest sense) consists of integrated elements (from the three models assessed in this paper) relating to characterizing the client and the co-relational aspects of client with facilitator. The *What* phase – wherein '*what*' mirrors the most potent, 'what-format' questions (for example, What is important about _____?) that facilitators can pose to clients in service of exploring change possibilities – incorporates the processes and techniques that can be utilised to explore and promote change. The *Where/How* phase (*where* in the client's life and behaviour can change be made and *how* can those new changes be made impactful) includes key elements in effectuating or making behaviour change real, consistent, and long-term. Clearly, health professionals require help in becoming adept at the skills and processes that might be utilised in each phase. Envisioning *MC* in the fashion depicted in Figure 1 provides an integrated framework that encapsulates and reconfigures the significant features of Motivational Interviewing, Egan's Skilled Helper Model, and the Co-Active Coaching Model in service of effective health behaviour change for health professionals and their clients.

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